

SCALE-UP OF STANDARD DAYS METHOD® IN INDIA

C O U N T R Y B R I E F



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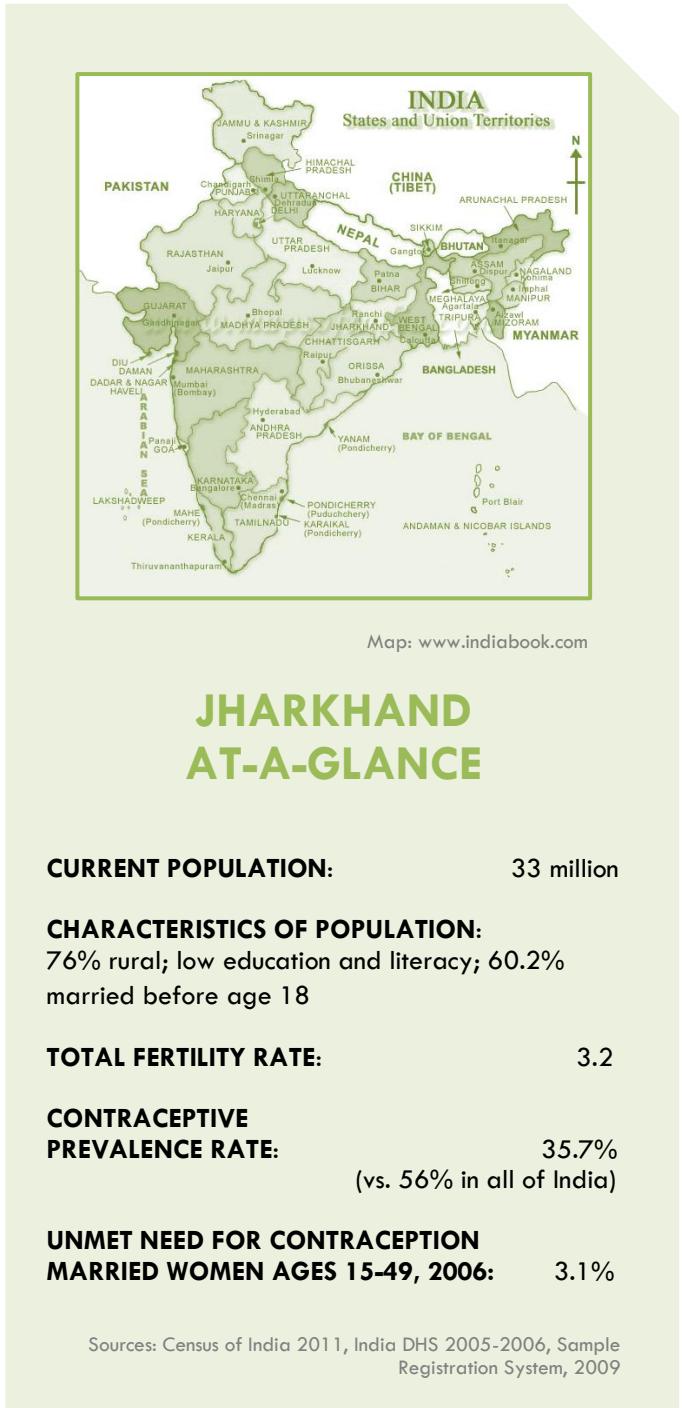
FAM
PROJECT
IRH GEORGETOWN UNIVERSITY

Since the early 2000s, the Institute for Reproductive Health at Georgetown University (IRH) has introduced and tested the Standard Days Method® (SDM) in a variety of service delivery settings around the world. IRH and partners are now scaling up SDM services in family planning (FP) programs in Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda. This report summarizes events in the state of Jharkhand in India, including choices, approaches and results of systematic SDM scale-up and related research. It concludes with an analysis of factors that influenced scale-up.

India's national FP program was launched in 1951, and was the world's first governmental population stabilization program. For many decades, the FP program emphasis was on sterilization, resulting in limited adoption of reversible methods and information about the benefits of birth spacing. However, following the 1994 International Conference on Population and Development (ICPD), which recommended high-quality services and a range of methods, the Government of India (GOI) also adopted a target-free approach to FP within the framework of informed choice, making client centered approaches the mainstay of their program. IRH's work to expand access to SDM in Jharkhand reflects the state of Jharkhand's desire to improve FP services and options for its citizens.

The state of Jharkhand is home to 33 million people, larger than all but 30 nations in the world. Most of whom live in rural areas and have low education and literacy rates. A new state in the Indian union, Jharkhand was created in 2000 from the southern portion of the state of Bihar. Although the Government of Jharkhand inherited a weak public health system, there were no entrenched policies and the new state was willing to adopt innovative strategies to tackle health challenges.

Jharkhand's reproductive health (RH) situation was poor. Early childbearing and closely spaced births contributed to high infant and maternal mortality. The total fertility rate was among the highest in India (3.2, SRS, 2009) and contraceptive use was low—about 36% in 2006 and mostly due to female sterilization. Use of IUDs, pills and condoms was particularly low. The Government of Jharkhand saw the potential for culturally acceptable methods such as SDM that could help women delay and space births.



INTRODUCTORY PHASE 2001 - 2007

IRH had worked in India before it introduced and subsequently scaled up SDM delivery in Jharkhand. After a multi-country study established the efficacy of SDM, USAID funded IRH and several Indian organizations to assess the feasibility of introducing SDM in India. From 2001-2004, IRH conducted two operations research studies to test the feasibility of offering SDM in community-based RH programs. One was in rural Uttar Pradesh (with CARE in Sitapur district), the other in Delhi slums (with Community Aid and Sponsorship Program and CEDPA). Results of these studies indicated that in both rural and urban areas there was a demand for SDM, users were highly satisfied with the method, women liked the lack of side effects and health risks, the method could be easily taught by providers and community health workers (CHW) and correctly used by women and their partners.

These results attracted the interest of the GOI Ministry of Health and Family Welfare (MOHFW) and led to integration of SDM into several national-level documents. In 2005, the GOI included SDM in its Reproductive and Child Health--Phase Two Program Implementation Plan, and UNFPA and the GOI included SDM in their Contraceptive Update Manual for medical officers. Interest in SDM within India continued to grow, and IRH began to work with a wider range of partners to integrate SDM into the FP initiatives of various NGOs. The MOHFW of the State of Jharkhand also became interested in SDM as a result of the successful introduction studies.

In 2004, the Jharkhand MOHFW, IRH, and other partners including CEDPA and Krishi Gram Vikas Kendra—a Jharkhand-based health and development NGO—jointly designed a USAID-funded introduction study that would test the integration of SDM into the state's RH/FP and child health services program. The study introduced SDM in public health services in two blocks of Ranchi district with a population of about 200,000; a third block served as a control. This was the first time SDM was offered by public sector health services in India.

The study results offered compelling evidence to the Jharkhand MOHFW that SDM was appealing to women and men and feasible to offer in the public sector by all levels of providers. Results of the introductory phase were disseminated at meetings where the Jharkhand MOHFW officials publicly stated their desire to scale-up SDM. The testimony of SDM providers and users from Jharkhand provided additional support to this decision.

RESULTS OF SDM INTRODUCTION STUDY IN RANCHI, JHARKHAND 2004-2007

- 30% of new FP users chose SDM
- 88% of SDM users had never used FP, suggesting that SDM attracts first-time users
- Simulated client results showed that MOHFW providers, Anganwadi workers, and CHWs all provided high-quality SDM services
- Community-level workers were key to expanding access
- Introducing SDM improved FP counseling overall- especially for condoms

SCALE-UP PHASE 2007 - 2013

The Jharkhand MOHFW wanted a step-by-step scale-up process, with technical assistance from IRH beginning in three districts and adding two to three more districts per year. Under this plan, half of Jharkhand's 24 districts would be fully covered at the end of a five-year scale-up period. The MOHFW selected Gumla, Deoghar, and Chatra as the first three districts because of their low CPR. In October 2007, the MOHFW issued formal notification letters to the three districts, thereby officially commencing the SDM scale-up phase and the IRH-MOHFW affiliation. These letters permitted IRH to begin orientation meetings and conduct master trainings in the three districts. The scale-up partnership was solidified in October 2008 when the MOHFW officials signed a Memorandum of Understanding

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN JHARKHAND, INDIA?

As of May 2013:

SERVICE EXPANSION

SDM services are available in 1900 service delivery points in the state of Jharkhand.

Four organizations are able to build others' capacity to offer SDM

INSTITUTIONALIZATION

SDM has been integrated into the following components of the national FP program and subsystems:

- Norms, policies, guidelines
- in-service training curricula
- Logistics system
- Health Information reporting system

SDM USERS & KNOWLEDGE OF SDM OPTION

49.1% of women and 41.8% of men in Jharkhand heard of SDM at endline.

Among women using FP at endline, about 6% were using SDM.

with IRH to commit approximately US \$200,000 to be invested in government scale-up activities, including trainings, communication materials, and CycleBeads® procurement.

IRH adopted the World Health Organization's ExpandNet framework for scaling up SDM in Jharkhand. This framework guides the scale-up process, its components and goals, and the technical assistance needed to achieve those goals. Through participatory meetings that brought together ExpandNet experts from WHO with IRH, USAID/India and Jharkhand's MOHFW stakeholders, initial planning was strategic and systematic. Goals, benchmarks and subsequent activities focused on both *horizontal* scale-up—the geographic expansion of SDM through availability of information, trained providers and CycleBeads—and *vertical* scale-up—institutionalization of SDM in all state systems required for maintaining sustainable, quality services. These include policies, budgets, procurement, logistics, health information systems, monitoring and evaluation, training curricula and ongoing demand creation activities.

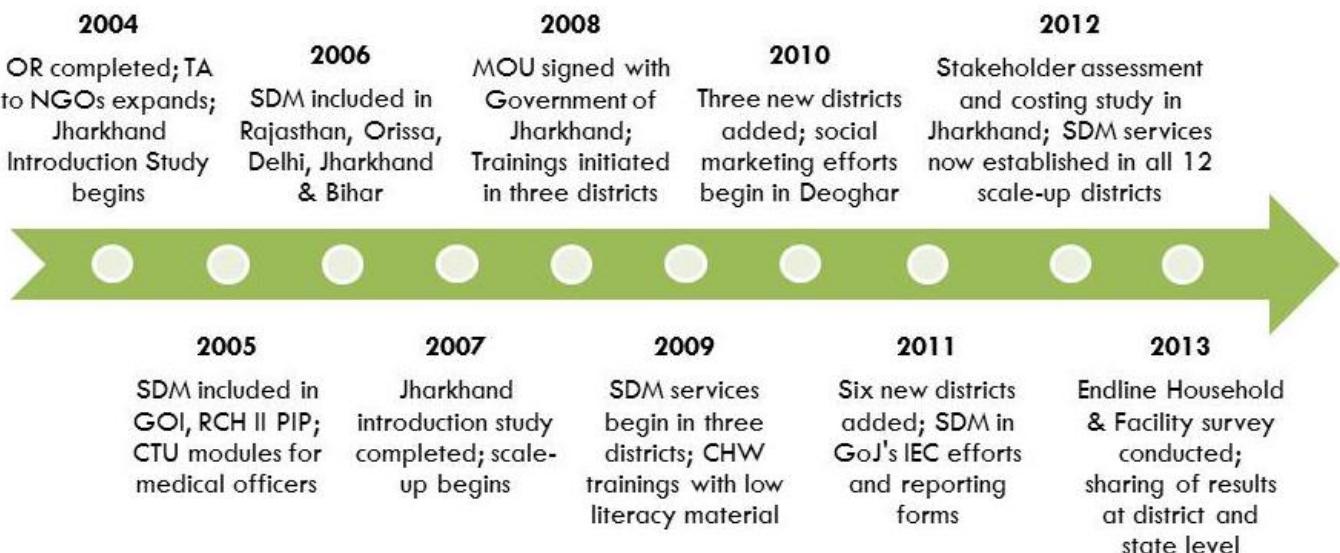
SDM integration was not narrowly defined. It was geared towards strengthening the FP program in general and provision of SDM and LAM services in particular so that the MOH/FW system would be better equipped to provide a full range of birth spacing methods and high-quality counseling thus maintaining the principle of informed choice for clients. SDM scale-up in India was guided by principles of *systems thinking, sustainability, scalability, and respect for equity*, as articulated by the ExpandNet framework. Scalability was a key concern and led to streamlining and simplifying SDM provider training and client materials to make SDM scale-up easier. To advance equity, gender issues were addressed in counseling and IEC, and scale-up focused on reaching the most underserved and isolated segments of the population. IRH advocated with MOHFW officials throughout the scale-up phase to ensure their continued support.

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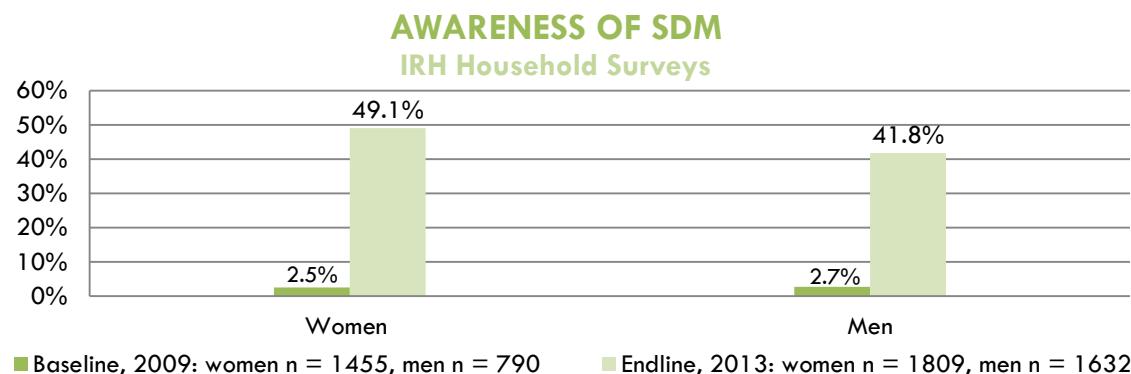
USING DATA TO GUIDE SCALE-UP

A variety of data, both quantitative and qualitative, was regularly collected to monitor scale-up, make midcourse corrections, and evaluate results. Documenting the scale-up process helped identify gaps and take corrective action. It provided evidence on successes to replicate and failures to avoid. For example, the midline service delivery point (SDP) survey found that there were stock-outs of FP commodities (defined as absence of commodities in the last three months): in 24% of SDPs CycleBeads were unavailable and in 26% condoms were unavailable. By the time of the endline survey, IRH and the Jharkhand MOHFW had succeeded in reducing stock-outs, and only 7% of facilities lacked CycleBeads and 9% lacked condoms. Similarly, inadequacies observed in SDM counseling led to reinforcements on site which improved the performance of providers. Ongoing quality improvements led to a shift of attitudes among representatives of stakeholders. Initially skeptical about the

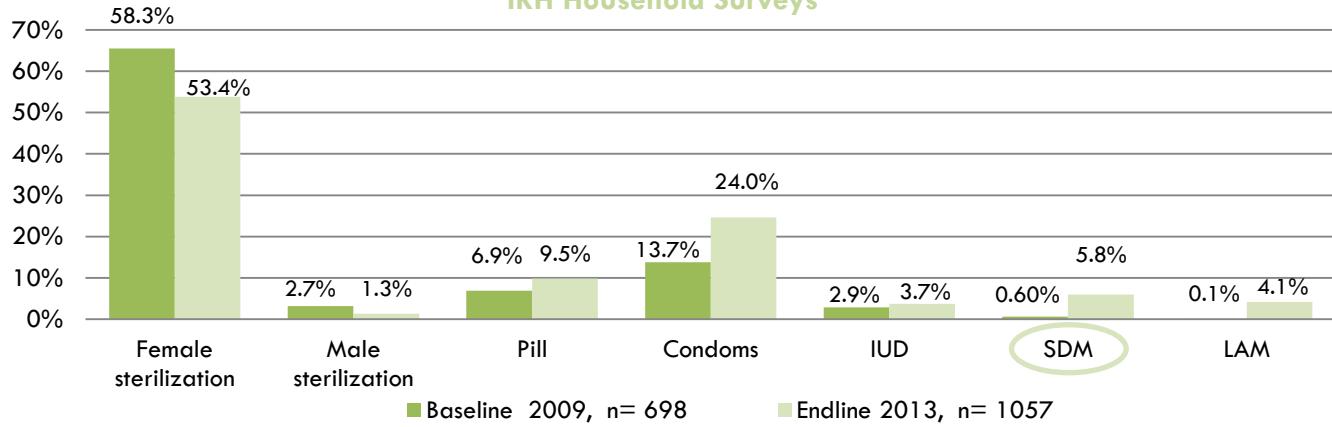
feasibility of SDM training at the baseline interviews, by the endline interviews these stakeholders had fully endorsed further training.



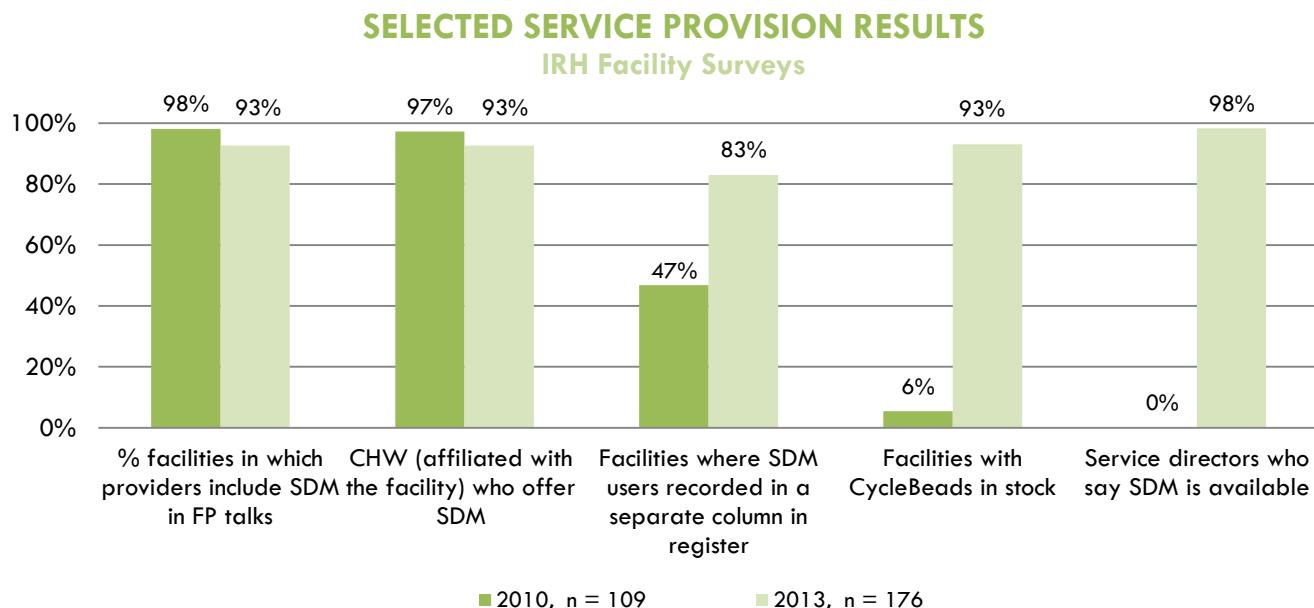
AWARENESS AND USE: Awareness of SDM among women increased from 2.5% at baseline to 49.1% at endline household surveys; a similar increase, from 2.7% to 41.8%, was also found among men. Among women practicing FP, the percent using SDM increased from 0.6% at baseline to 6.0% at endline. It was also important to ensure that clients who had chosen SDM were using it correctly. Through client follow-up, IRH determined that in most areas, 80 to 90 percent of clients were using the method correctly.



METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING IRH Household Surveys



SERVICE PROVIDER CAPACITY AND METHOD AVAILABILITY: SDM knowledge and skill among service providers were measured through systematic use of a competency checklist during ongoing program supervision and endline facility assessments. Endline surveys with providers found that 98% were aware of SDM and 87% had offered it in the last year. Assessments of over 2500 providers during regular supervision found that the mean score for knowledge about how CycleBeads work was 84% and their ability to screen for cycle length criterion for the method was 88.7% combined for physicians, nurses, ANMs and community workers. Recording of SDM users was reported by 67% of service providers interviewed during the endline survey. The chart below shows selected results on service provision in 2010 and 2013.



ACHIEVEMENT OF SDM SCALE-UP BENCHMARK TARGETS

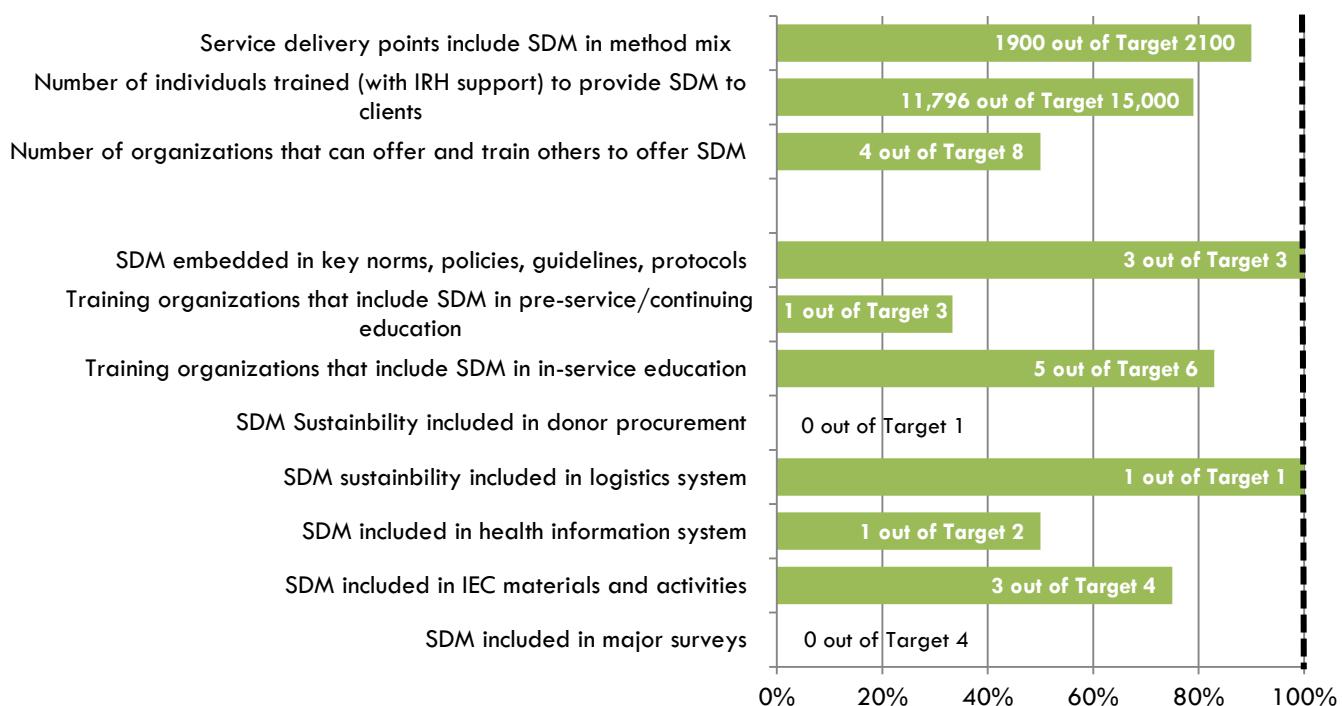
The table below presents the substantial endline achievements in SDM scale-up as a proportion of the benchmark targets that IRH and the MOHFW set for Jharkhand, for both horizontal (geographic) and vertical (institutionalization) scale-up. The Jharkhand MOHFW and IRH were able to expand SDM availability to half of the 24 districts of Jharkhand, an area of approximately 12 million people, where it is now offered in 1900 of the 2100 SDPs that were projected to be operating by the endline. While this figure represents 90% of the benchmark target, it should be noted that two of the districts selected for scale-up in the third phase (2010) were smaller districts and therefore the number of SDPs and providers were lesser than projections made in 2007- 2008. So the success rate could be considered to be higher than 90%.

Almost 12,000 out of 15,000 providers were trained and five of six training organizations included SDM in their in-service training curricula. In addition, IRH built the capacity of four of eight service MOHFW delivery organizations to become trainers as well as providers of SDM; these resource organizations are crucial to sustainability. Efforts at the Jharkhand State level to include SDM in norms, policies, guidelines, protocols, as well as the logistics system, were successful. Integration of SDM in IEC radio, client (materials and community activities) was also achieved in three of the four planned programs, including social marketing efforts.

PROPORTION OF BENCHMARK TARGETS ACHIEVED, JHARKHAND, INDIA

Horizontal

Vertical



There were some external factors that prevented IRH from achieving 100% of all benchmarks. For example, the Jharkhand MOHFW planned in 2009 to develop training modules for *Sahiyyas*, a new cadre of rural outreach workers, into which a unit on SDM would be integrated. However, there were many delays and the curricula, which included SDM, were not printed until spring 2013, after the IRH endline evaluation. The *Sahiyyas* are now being trained with a new FP module that includes SDM. In the last year of scale-up, when SDM had established a successful track record, IRH was able to focus on pre-service education. Workshops were completed with six academic institutions to equip faculty with resources to integrate SDM in syllabi. At endline, one university had already integrated SDM into the nursing curriculum, and others are likely to follow suit. However, SDM in nursing pre-service curricula at the central level remains to be accomplished as these efforts are led by the GOI, which has yet to recognize SDM in the national FP norms; this is also the reason major surveys have not included SDM.

SCALE-UP AND THE JHARKHAND ENVIRONMENT

Although India's health program is largely decentralized, national policies affect state programs, and this held true for Jharkhand's MOHFW. The main issue affecting scale-up was that SDM was not part of the GOI's FP program.

While Jharkhand's MOHFW decided to integrate SDM into the state's FP program, lack of inclusion of the method in the national program posed challenges to scale-up. For example, unlike other methods CycleBeads distributed through services during the scale-up period were donated by the project as they could not be procured by the state. States procure contraceptives through a central procurement mechanism but, because SDM was not part of the national FP program, the MOHFW could not procure CycleBeads centrally. IRH facilitated meetings with the local manufacturer, HLL Lifecare Ltd and the MOHFW to negotiate procurement of CycleBeads. Still, procurement by the MOHFW did not succeed by the end of the scale-up phase. While the Jharkhand MOHFW keeps track of SDM at the local level, it must follow national requirements for reporting of service statistics using national GOI

standard forms which have yet to include SDM. The MOHFW, however worked through this situation by a directive clearing the reporting of SDM users by adding a column in their reporting formats. This meant extra work for providers to record SDM, but was accomplished. These and other instances towards integration efforts indicated that the most effective advocacy with GOI would be to demonstrate successful scale-up in Jharkhand.

Other environmental factors affected scale-up. There was frequent turnover of Jharkhand MOHFW leaders at state and district level which meant that IRH requested briefing meetings with new leaders to share updates, brief them on SDM scale-up, and gain their support. To overcome the challenge of travelling to remote districts from Ranchi, the state capital, to provide technical assistance, IRH decided to assign a district coordinator in each district. In addition, political instability in the state often put activities on hold or slowed down the process and caused suspension of scale-up activities. Beyond the MOHFW health system, few large-scale non-governmental health networks exist. While NGOs were active in many districts, their donor grants could not include SDM scale-up, and the many private health providers in Jharkhand operated independently. Thus, IRH focused on the MOHFW as the main user organization. Furthermore, the Jharkhand MOHFW had requested SDM scale-up and proved a steadfast partner.

RESOURCE AND USER ORGANIZATIONS

IRH's strategy was to expand its reach and impact by working through partnerships with donor agencies, government agencies, institutions, and NGOs. A large number of such organizations gained the capacity to provide SDM services, typically within FP/RH programs that were strengthened overall as a result of IRH TA; these are referred to as 'user organizations.' At the end of the scale-up period, several entities were also 'resource organizations.' This means they could train and supervise others to offer SDM. They could also adapt training content, develop IEC items, engage in demand creation activities, and facilitate information-sharing and mutual capacity-building among peers.

PSI, with funding from IRH, piloted the social marketing of CycleBeads in Deoghar district and sold about 4,000 sets. Jhpiego, IntraHealth, and Futures Group participated actively in partner meetings at the state level, but their projects were located outside of the SDM scale-up districts. Because of the limited role of development partners and in the absence of networks of local NGOs or private providers, the Jharkhand MOHFW became both the main resource organization and the main user organization.

A primary objective of scale-up was for IRH to build the capacity of the Jharkhand MOHFW to serve as its own resource organization, thus contributing significantly to sustainability. To achieve this, it was important that key MOHFW personnel be involved in planning and implementing scale-up from the beginning by serving as members of the resource team. Important MOHFW personnel included the Health Secretary, the NRHM Mission Director, Family Planning Cell, the Reproductive and Child Health Officer, and several others all based in Ranchi. IRH's district coordinators worked with district level MOHFW officials, block-level Medical Officers, and program managers, to schedule FP trainings in the district and block, conduct IEC activities and oversee other important components. State- and district-level partner meetings encouraged MOHFW ownership of, involvement in, and accountability for scale-up planning and management.

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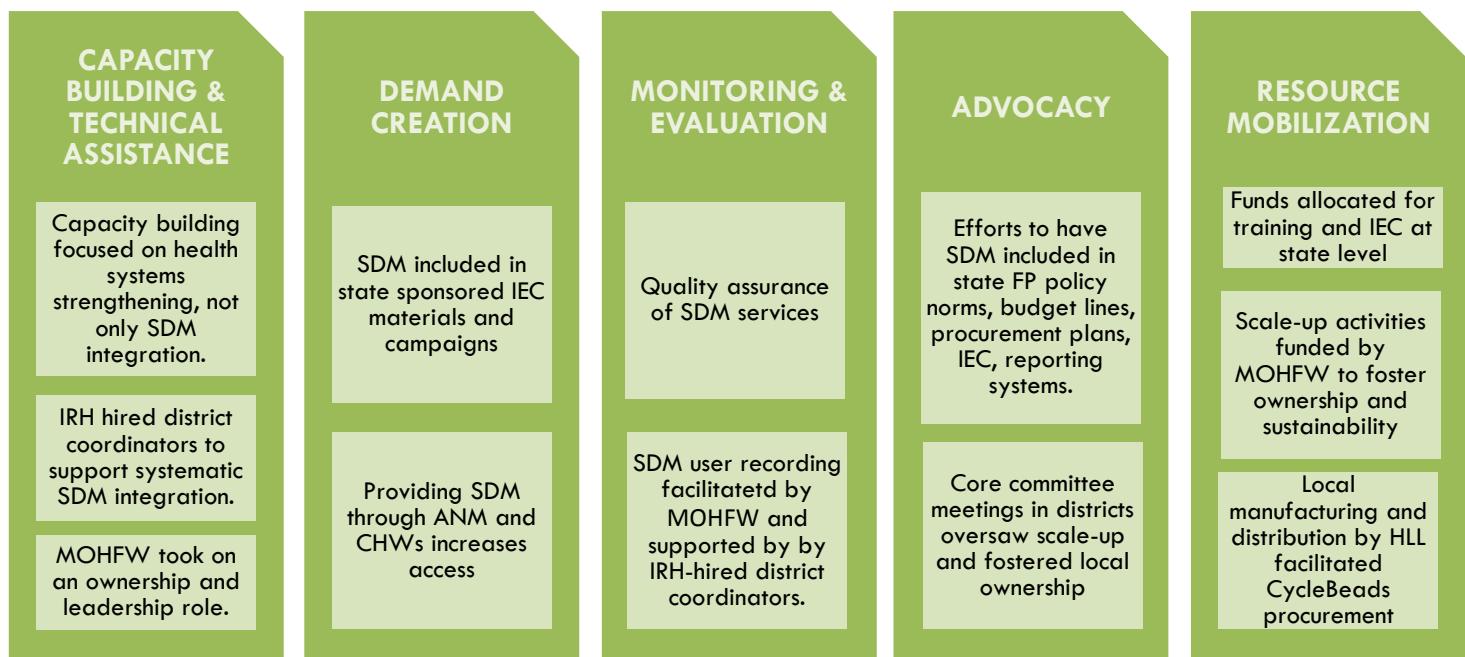
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The Jharkhand MOHFW also represented an ideal user organization because its reach was enormous. It operates an extensive network of health facilities that cover every district and block with support of a new cadre of CHWs called *Sahiyya* that have a presence in every village. Equally important, the MOHFW could set its own FP norms and policies (under the overall aegis of the central government) and had funding for its FP program, increasing the likelihood that integration and scale-up could be sustained. The goal of scale-up was to integrate SDM into the Jharkhand MOHFW's FP services in 12 of its 24 districts, at both facility and community levels. After health system strengthening, training, and training of trainers, this goal was achieved. As of May 2013, SDM was being offered in all facilities from primary health centers to the sub-centers that serve as peripheral outposts.

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STRATEGIC CHOICE AREAS



The ExpandNet framework guides implementers to make strategic choices in several areas based upon their operating environment. These areas, as they applied to scale-up in India, are briefly summarized here.

CAPACITY BUILDING AND TECHNICAL ASSISTANCE: IRH worked to build the capacity of the Jharkhand MOHFW to offer SDM services and to improve the FP program in general. Training MOHFW staff in each district to serve as master trainers was a way to build in-house capacity, strengthen the health system, and ensure sustainability of SDM within the user organization. IRH streamlined SDM training to fit a two-hour time frame within the CTU program schedule to facilitate the method's integration within the existing basket of services. A cascade-training approach, combined with mentoring and monitoring to ensure quality, was employed. IRH's district coordinators worked with district and block authorities to develop the training schedules. Emergence of a new cadre of providers, the *Sahiyas*, during SDM scale-up resulted in the need for new training approaches. The need to train low-literacy providers prompted a shift to shorter, more structured training methodologies that were implemented in conjunction with new pictorial CycleBeads instructions.

MONITORING AND EVALUATION: Documentation of key elements of the scale-up process and their outcomes included data at the program, provider and client levels. To monitor scale-up, IRH collected data that offered insights into progress in each block. This included comparing providers' CTU post-test scores in a given block with the block's service statistics to identify opportunities to improve their training. Engaging MOHFW officials at state and district levels in regular review of M&E data during partner and one-on-one meetings helped build the capacity of MOHFW staff to collect and use data to make program adjustments.

ADVOCACY: IRH initiated SDM scale-up at the request of the Jharkhand MOHFW, but frequent turnover of officials resulted in a lack of institutional memory within the system. Constant advocacy with MOHFW, involving routine meetings at many levels was essential to ensure ongoing commitment to the process and actions to achieve institutionalization of SDM. IRH's work in various districts and the significant evidence base it built – during both the introductory and scale-up phases – led the MOHFW to perceive it as a credible advocate. The MOU between IRH and the Jharkhand MOHFW in which the government committed to investing more than \$200,000 to SDM scale-up represented a great advocacy success. This demonstrated not only of the government's commitment to the scale-up process, but also their appreciation of the work IRH had done up to that point.

RESOURCE MOBILIZATION: IRH received funding from USAID, but scaling up SDM services to approximately 12 million people required additional resources. It was therefore essential to leverage funds. The Jharkhand MOHFW contributed significant resources to scale-up that paid the costs for SDM and CTU trainings of MOHFW providers. It also paid for printing of training curricula and comic books, IEC materials, including items such as World Population Day billboards which included information on SDM. Finally, the MOHFW provided office space to IRH in Ranchi and at most of the districts at no cost.

As a result of IRH advocacy, HLL Lifecare Limited, the largest contraceptive manufacturer in India and a GOI enterprise was established as a producer of CycleBeads. It was important to Indian stakeholders that CycleBeads be manufactured in-country, as procuring CycleBeads from abroad was not an option. HLL signed agreements in December 2009 to become an authorized CycleBeads manufacturer, and further rebranded the product for social marketing and private-sector sales.

KEY ELEMENTS THAT FACILITATED SCALE-UP IN JHARKHAND, INDIA

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The Jharkhand MOHFW was a strong partner which could continue SDM delivery and demonstrate to the national and other state governments the benefits of including SDM in their FP programs	Participatory meetings throughout Jharkhand facilitated a strong partnership between IRH and the MOHFW	Health systems strengthening through both systems integration and advocacy	Quality monitoring and adaptability when transitioning from introduction to scale-up

The ExpandNet framework encouraged strategic decision-making that facilitated the scale-up process.

Choosing the right partner. Working with the Jharkhand MOHFW was the right choice. It was the largest FP service delivery organization in the state and had its own funds with which it could continue SDM service delivery and training after IRH's involvement ended. In addition, Jharkhand's successful experience in scaling up SDM could demonstrate to the GOI and other state governments the benefits of integrating SDM into their FP program, making scale-up throughout India more likely.

The importance of reputation. From the earliest days, IRH organized participatory orientation meetings and trainings, even in the poorest and most distant corners of Jharkhand state where few other organizations would work. This fostered respect and good will on the part of the MOHFW and served scale-up well: it facilitated a strong partnership between IRH and the MOHFW, and opened doors to scale-up opportunities.

The need to go beyond systems integration. Integrating SDM into systems, such as policies, norms, budgets, procurement, HIS, training curricula, and IEC was essential to sustainability but was not sufficient. Health system strengthening was required as well as ongoing advocacy to ensure that actors within the health system stayed committed to new SDM-related policies.

Quality control and adaptability during the transition from introduction to scale-up. In scaling up SDM, it was not possible to apply the same level of resources and monitoring to a huge geographic area with a population of millions. Approaches had to be modified, including simplifying training curricula, CycleBeads user instructions, and counseling guides. Quality monitoring made sure the modified innovation was as effective as the original.

SUSTAINABILITY OF SDM IN JHARKHAND, INDIA

Significant progress has been made across the various components of scaling up SDM at the state level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, there is a need to identify key actors and strategies that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

SCALE-UP COMPONENT	ACTION FOR SUSTAINABILITY	RESPONSIBLE PARTY
ADVOCACY	<ul style="list-style-type: none">Advocate for SDM inclusion in national- level policies and programsAdvocate for support for SDM expansion from USAID and other donors	USAID , HLL and MOHFW MOHFW
CAPACITY BUILDING	<ul style="list-style-type: none">Ensure SDM is part of FP activities in new procurementsInclude SDM in state FP training programs & curricula, such as <i>Sahiyya</i> trainingExpand SDM integration to remaining 12 Jharkhand districtsReinforce SDM/LAM provider competencyIntegrate SDM in other nursing schools following the example of Jamia Hamdard University.	USAID MOHFW , USAID MOHFW , USAID MOHFW MOHFW , USAID
LOGISTICS AND PROCUREMENT	<ul style="list-style-type: none">Purchase CycleBeads from HLLAdvocacy for purchase of CycleBeads	MOHFW USAID and HLL
IEC	<ul style="list-style-type: none">Ensure SDM and LAM included in IEC materials and campaigns	USAID and MOHFW
HMIS/ MONITORING & EVALUTION	<ul style="list-style-type: none">Monitor that SDM and LAM information is completely and correctly recorded in HMISEnsure HMIS have space included for SDM state-wideInclude SDM in next state-wide survey	MOHFW MOHFW MOHFW, USAID